No. 89-1048

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

FMC CORPORATION,
Petitioner,

v.

CYNTHIA ANN HOLLIDAY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF AMICUS CURIAE OF THE SELF-INSURANCE INSTITUTE OF AMERICA, INC. IN SUPPORT OF THE PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

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The Self-Insurance Institute of America, Inc. ("SIIA") submits this *amicus curiae* brief with the consent of both FMC Corporation and Cynthia Ann Holliday.[1]

INTEREST OF THE AMICUS

SIIA is a non-profit corporation composed of over 700 members dedicated to the advancement and protection of the self-insurance industry. SIIA's membership includes users of self-insurance such as employer plan sponsors, as well as service providers

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[1] Original consent letters from both FMC Corporation and Cynthia Ann Holliday have been lodged with the Court.

such as third-party administrators, reinsurance companies, and other entities engaged in the self-insurance business. SIIA is the only association in the U.S. which represents firms, professionals, and organizations which participate in the broad spectrum of self-insurance, including self-insured group health plans.

Through SIIA, its members coordinate their views and provide practical information and recommendations to government and the public on how the self-insurance system functions, and on the impact of government regulations and interpretations under the Employee Retirement Income Security Act of 1974, ("ERISA") 29 U.S.C. §§ 1001 *et seq.*, concerning self-insured health plans and plan participants. This includes rendering assistance to courts in their deliberations on significant self-insured health plan issues of broad concern to members.

SIIA has an interest in the ERISA preemption issue presented in this case—whether a state anti-subrogation law applies to a self-insured health benefit plan—for three reasons. First, the issue presented is of major concern to the self-insurance industry because the rising cost to employers of providing health benefits will escalate further if states may prohibit member companies from including subrogation provisions in their plans similar to the clause invalidated by the Third Circuit. This will result either in reduced health care benefits, or higher out-of-pocket costs for participants in the form of higher co-payments and deductibles, or both. The Third Circuit's decision may even threaten the continued viability of self-insurance as a cost-efficient alternative for providing health benefits to millions of employees. Second, because many SIIA employer members

operate on a multi-state basis, they are legitimately concerned that any erosion of ERISA's preemption provisions will not only severely disrupt the operation of their plans but will also open the door to additional state insurance regulation which will severely hamper their efforts to administer their plans on a uniform and cost-efficient basis—precisely the objectives Congress sought to achieve through federal preemption. Third, if state anti-subrogation statutes apply to employee benefit plans, the risk of loss for injuries caused by third parties will needlessly shift to employer-sponsored plans thus creating a "windfall" for employees who receive duplicative recoveries from the responsible party.

Accordingly, SIIA files this *amicus curiae* brief in support of the petitioner.

SUMMARY OF ARGUMENT

In concluding that the Pennsylvania anti-subrogation law applies to an uninsured health plan, the court of appeals overlooked the scope and purpose of ERISA's so-called "deemer" clause which insulates self-funded plans from state law. By finding that ERISA'S deemer clause was applicable only when state laws affected undefined "core ERISA concerns", the court of appeals contrived a vague new judicial standard which ignores ERISA's express goal of promoting uniform employee benefit regulation. This finding is unsupportable in light of ERISA's explicit preemption language and its legislative history. The court of appeals also failed to recognize the time-honored distinction between conventional insurance and self-insurance which was codified by Congress in ERISA's deemer clause and which has been consistently recognized by this Court.

The Third Circuit's decision creates an ill-conceived precedent which directly affects thousands of self-funded health plans which provide benefits to millions of participants. Since the passage of ERISA, SIIA members have established and administered self-funded plans in reliance upon a federal legal framework which expressly recognizes the distinction between insurance and self-insurance. SIIA members are deeply concerned that state anti-subrogation statutes which prevent recovery of duplicative health benefit payments will result in a "windfall" to participants who receive such payments and a "dead loss" to self-funded plans. This will significantly increase overall health plan costs and will have detrimental implications both for participants who will bear the ultimate cost-shifting burden of those costs, and for the continued growth of self-insured health benefit programs as a viable and cost-efficient alternative to conventional insurance.

ARGUMENT

I. THE THIRD CIRCUIT FAILED TO RECOGNIZE THE DISTINCTION BETWEEN INSURANCE AND SELF-INSURANCE WHICH WAS CODIFIED BY CONGRESS IN ERISA

In holding that a state insurance law applies to a self-funded health plan, the Third Circuit ignored ERISA's express statutory language and this Court's holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) that the deemer clause exempts such benefit plans from state regulation. As this Court pointed out in *Metropolitan Life*, "uninsured" employee benefit plans are not open to even "indirect regulation" under state law. 471 U.S. at 746-47.

There can be no serious dispute that the distinction between insurance and self-insurance was recognized by Congress when it enacted ERISA's deemer clause:

> Neither an employee benefit plan nor any trust established under such plan shall be deemed to be an insurance company . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts.

29 U.S.C. § 1144(b)(2)(B). Interpreting this provision in *Metropolitan Life* (involving a Massachusetts statute which mandated minimum mental health care benefits), this Court held that ERISA did not preempt the state insurance law as applied to *insured* health plans but that *uninsured* employee benefit plans were exempted from the state statute's reach. *Metropolitan Life*, 471 U.S. at 738-47. This Court concluded:

> Our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction Congress is unaware of and one it has chosen not to alter.

Id. at 747. Thus, while a state anti-subrogation law such as the Pennsylvania statute involved in this case may apply to an insurance contract or indirectly to a plan which purchases an insurance contract, it cannot apply to a self-funded plan.

ERISA codified this well-established distinction in 1974 when it adopted a broad preemption provision. ERISA Section 514(a) provides quite simply and directly that the provisions of Titles I and IV of ERISA shall preempt "any and all State laws inso-

far as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Although Congress sought uniform federal regulation of benefit plans, state laws regulating insurance were exempted from the broad preemption provision under the so-called "savings clause" in Section 514(b)(2)(A) which was intended to preclude ERISA preemption in areas reserved to the traditional state regulation of the "business of insurance." 29 U.S.C. § 1144(b)(2)(A). *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1976).[2] However, Congress added Section 514(b)(2)(B), the deemer clause, which limits the scope of the insurance savings clause and prohibits state regulation of self-funded plans.

It is well settled that where, as in the deemer provision, "Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." *Andrus v. Glover Construction Co.*, 446 U.S. 608, 616-17 (1980). That contrary intent is not to be found in the legislative history of ERISA. Instead, ERISA and its legislative

[2] In enacting McCarran-Ferguson, Congress declared that "the continued regulation of the *business of insurance* is in the public interest." 15 U.S.C. §§ 1011-1015. In enacting ERISA, Congress reserved to exclusive Federal authority the regulation of the field of employee benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 120 (1983). Note that drawing upon the "analysis of the McCarran-Ferguson Act," the Eighth Circuit distinguished subrogation from the "business of insurance," stating that: "The practice of subrogation does not transfer the risk from a policyholder to his or her insurer. Rather, it limits the recovery available to the policyholder by preventing a double recovery." *Baxter v. Lynn*, 886 F.2d 182, 186, *reh'g denied*, —— F.2d —— (8th Cir. 1989).

history explicitly—indeed, unqualifiedly—show that Congress knew exactly what it wanted to accomplish in Section 514(b)(2)(B) to prevent the savings clause from leading to a characterization of employee benefit plans as insurance companies—and used unmistakably plain language to achieve that objective.[3]

In concluding that ERISA does not insulate self-funded health plans from state regulation, the Third Circuit ignored the plain language of the deemer clause and instead fashioned a new judicial standard to invalidate the subrogation provision. Contrary to the great weight of authority upon which the self-insurance industry has relied,[4] the Third Circuit con-

[3] Faced with the conflicting and uncertain basis for regulation among the states, the "deemer" language was utilized to create an *irrebutable presumption* that these plans are not insurance trust companies, etc., for purposes of state regulation . . . . The irrebutable presumption would not be overcome even if an employee benefit plan engages in activities which bring it within the insurance . . . activities generally regulated by a state. Activity Report of the Committee on Education and Labor, Rpt. No. 91-1785 (January 3, 1977) (Emphasis Added).

[4] *See Baxter v. Lynn*, 886 F.2d 182, *reh'g denied*, —— F.2d —— (8th Cir. 1989); *Reilly v. Blue Cross and Blue Shield of Wisconsin*, 846 F.2d 416 (7th Cir. 1988), *cert. denied*, 109 S.Ct. 145 (1988); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Standard Oil of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1979), *aff'd mem.*, 454 U.S. 801 (1981); *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978). In *Insurance Board of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987),

cluded that the deemer clause exempts self-funded health plans from state laws only in cases where the state law affects a "central concern of ERISA." *FMC Corp. v. Holliday*, 885 F.2d 79, 89, *reh'g denied*, —— F.2d —— (3d Cir. 1989). This interpretation is contrary to ERISA's broad preemption provision and cannot be supported by a reading of ERISA's legislative history relating to preemption.

Indeed, in the final compromise version of ERISA, the Conference Committee rejected the narrow approach taken to preemption in earlier versions of ERISA and agreed on a substitute that was ultimately enacted into law. ERISA Leg. His., Vol. III at 4518.[5] Whereas earlier versions limited preemption to specific enumerated areas or to "the subject matters" regulated by federal law, the substitute elected deliberately to preempt all state laws "as they may now or hereafter relate to any employee benefit plan" subject to certain enumerated exceptions. In short, "Congress made a clear-cut decision not to identify various subjects on which state laws were to be preempted, but instead sought to avoid constant litigation over the scope of preemption by preempting, with certain limited exceptions, 'all' state laws insofar as they 'relate' to plans covered by ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987). *Perrel Industries, Inc. v. Connecticut Commission on Human Rights*, 468 F. Supp. 490, 492

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the Third Circuit itself has also held that ERISA preempts state insurance law as applied to self-insured health plans.

[5] Citations to "ERISA Leg. Hist." refer to the separately bound legislative history: Senate Comm. on Labor and Public Welfare, Subcomm. on Labor, 94th Cong., 2d Session, Legislative Histroy of ERISA (Three Volumes) (1976).

(D. Conn. 1978), *aff'd*, 603 F.2d 214 (2nd Cir. 1979), *cert. denied*, 444 U.S. 1031.

ERISA's original language limiting preemption "only to state laws relating to specific subjects regulated by ERISA," was amended to reflect Congress' desire to preempt the entire field with regard to benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 104. ERISA preemption "is not to be limited to those state laws which deal specifically with ERISA plans or with subject matters covered by ERISA plans". *Baxter v. Lynn*, 886 F.2d at 195.

That this shift in approach adopted by the Conference Committee was a clear-cut and well thought-out decision is seen from the explicit statement made by Senator Jacob Javits, the ranking minority member of the Senate Committee on Labor and Public Welfare, who stated:

> Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibiilty of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme.
>
> Although the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interest of

uniformity with respect to interstate plans required—but for certain exceptions—the displacement of State action in the field of private employee benefit programs.

ERISA Leg. Hist. Vol. III at 4770-71. Thus, the Third Circuit's flawed reliance on a "core ERISA concern" test was explicitly rejected by Congress.

II. LIMITING THE SCOPE OF THE DEEMER CLAUSE WILL ADVERSELY AFFECT SELF-FUNDED HEALTH PLANS AND PLAN PARTICIPANTS

A. Health Plan Costs Will Increase

ERISA's preemption language provides a significant impetus for companies to self-fund employee health benefits. Congress helped foster the favorable federal legal regulatory environment that has resulted in a phenomenal growth of self-funded plans.[6] This growth also reflects recognition of self-insurance as a viable alternative to conventional insurance for funding health benefits, and as a cost-efficient method of providing expanded benefit coverage during a period of rapidly escalating health costs.[7]

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[6] According to a survey by Foster Higgins & Co. Inc., fifty-two percent of employers surveyed in mid-1989 self-insure their group health plans, up from 48% in mid-1988. Woolsey, *Most Health Plans Now Self-Funded,* Business Insurance, January 29, 1990 at 3. More than 50 percent of the U.S. workforce covered by group health plans participate in self-funded plans. *Self Insured Health Plans,* HCFA Review, Vol. 8 No. 2 (1986). The HCFA study also found that 74 percent of all firms with 1,000 to 4,999 employees self-fund their health benefits. The Foster Higgins survey found that 84% of employers with 20,000 or more workers self-funded their health plans in 1989, up from 73% in 1988. Foster Higgins at 10.

[7] In 1989, employers that self-insured health benefits reported much smaller cost increases than employers who purchased health plans from commercial insurers. Plan costs for self-funded employers rose 17.6% in 1989 to an average of $2,587 per employee from $2,200 in 1988. By contrast costs for insured health plans leaped 22.7% in 1989 to an average of $2,608 per employee from $2,125 in 1988. Foster Higgins, *supra* note 6 at 75.

An important factor which has contributed to this growth within the present federal regulatory framework is the flexibility of plan design. Subrogation clauses, a feature commonly found in employer-sponsored self-funded plans, are designed to preserve plan assets which can be used to pay enhanced benefits by allowing recovery of medical expenses which are the financial responsibility of other parties.[8] Generally, subrogation provisions permit plan recoveries for medical expenses paid by a plan for injuries sustained in automobile accidents, from product defects, in accidents on private or public property or for malpractice by hospitals and doctors, where such expenses are also payable to participants pursuant to legal action or settlement in civil cases. Subrogation recoveries do not reduce medical expenses which are otherwise paid to participants in the absence of a third party recovery. They simply eliminate duplicative payments, and preserve limited benefit dollars which are used to pay expanded health care benefits to participants.

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[8] Duplicate Medicare payments are also subject to recovery from beneficiaries by the Health Care Financing Administration for injuries already reimbursed by automobile and liability insurance. *See,* generally, CCH Medicare and Medicaid Guide ¶ 4142 (Vol. 1 at p. 1372); HCFA Reg. §§ 411.20 *et seq.*, CCH Medicare and Medicaid Guide ¶ 20, 881.32 to .54 (Vol. 4, pp. 8264-8274).

State anti-subrogation laws will, however, result in less money in plans to pay medical benefits thus forcing many employers to reduce or eliminate certain benefits. For example, faced with higher costs, employers are likely to restrict coverage for medical expenses related to negligent third-party injuries or to eliminate coverage for other benefits such as vision and dental care. In other cases, in order to maintain current benefit coverages and levels, higher plan costs will be shifted to plan participants in the form of higher co-payments and larger deductibles. Inevitably, state interference with sound cost-containment practices such as subrogation clauses will threaten the continued viability of self-insurance as an acceptable method of providing health benefits to participants.

B. The Administrative Burdens of Operating Self-Funded Plans Will Increase

Another negative effect of allowing state anti-subrogation laws to override ERISA's deemer provision is the increased complexity which will result from administering self-funded plans on a state-by-state basis. Since adoption of ERISA, such plans have been established and operated on a nationally uniform basis and free from state regulation. If subrogation clauses are invalidated, states will be encouraged to enact laws similar to the Pennsylvania anti-subrogation statute. Some states are likely to enact such statutes, while others will choose not to do so. Monitoring and compliance with varying and often inconsistent state statutes will create significant new administrative burdens. Instead of promoting order and greater uniformity, greater fragmentation and confusion will result.

Moreover, some states will feel emboldened to enact insurance laws and regulations which go beyond anti-subrogation laws and attempt to regulate a variety of subjects not deemed to be "core ERISA concerns." [9] Ultimately, employers and employees will bear the additional costs associated with such statutes.

C. The Continued Viability of Self-Insurance As An Alternative Method of Providing Health Benefits Is Threatened

It is a long-standing practice that certain risks, including the medical expenses of employees, can be financed by employers from their own current revenues. When such benefits are not insured, directly or indirectly, no insurance company is responsible for providing them. Indeed, even prior to ERISA, state courts understood that an employer who self-funds health benefits is not in the "insurance business." *Farmer v. Monsanto Co.*, 517 S.W.2d 129 (Mo. 1974).

Unlike conventional insurance where the risk of loss is *transferred* to an insurance carrier upon payment of a premium, self-insurance is generally understood to mean the *self assumption* (or retention) of one's own risk of a particular loss. As an integral part of a firm's risk management program, self-insurance can include the assumption of all or part of a firm's risk of loss for health benefits, property and casualty exposures and workers' compensation

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[9] For example, over 37 states have enacted insurance laws mandating over 700 special benefits. The treatment of alcoholism, mental illness and drug addiction are examples of such statutes—all of which may be characterized as not in conflict with "core ERISA concerns."

liabilities. Thus, employers seeking a cost-effective alternative to conventional insurance increasingly have adopted self-insured programs in managing various elements of risk related to the business enterprise.

Considerations which have stimulated the utilization of self-insurance for funding health benefits include direct control over claims settlements, greater flexibility to design and administer health plans to meet specific employee needs, cash flow advantages and freedom from state insurance regulation. For example, firms which pay for health benefits from general assets gain the financial advantage of the time-value of their capital assets. Since medical claims are paid as submitted, firm assets can be retained as working capital and invested. Thus, interest can be earned as funds that otherwise would be paid in the form of premiums for conventional insurance (which includes reserves) are retained by the employer. These unique characteristics and the favorable legal regulatory environment fostered by ERISA and the *Metropolitan Life* decision have contributed significantly to the dramatic expansion of self-insured health plans.

CONCLUSION

Inclusion of a broad preemption provision in ERISA was designed by Congress to displace state laws, primarily because of the increasingly interstate nature of employee benefit plans and the often conflicting state standards applicable to such plans. To limit the breadth of ERISA's deemer provision would close an important chapter in the development of ERISA's preemption policy and open a new chapter with significant adverse implications for employee

benefit plans. In sum, failure to reverse the Third Circuit's decision will open the door for state legislatures to enact statutes not deemed in conflict with core ERISA concerns which may even threaten the continuation of self-insurance as an attractive alternative for providing health benefits to millions of employees.

Respectfully submitted,

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